

Patient Health History Form

Chief Complaint

Why are you seeing the doctor today?

DOI:

Surgery Date:

Medication	Dose

Medication	Dose

See Medication Appendix

Allergy	Reaction

Allergy	Reaction

Past Medical History

- HTN
- Heart Attack
- Diabetes
- Cholesterol
- Pulmonary
- Arthritis
- Cancer
- Stroke
- Prostate
- Female
- Bleeding
- Thyroid
- Osteoporosis
- Ulcers
- Blood Clots
- HIV
- Hepatitis
- Other
- Other

Family History

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Job status Work in the home
Marital Single
Living situation Alone
Exercise Daily

Tobacco None
Alcohol None

Occupation:
Children: Yes

Type:

Use:

Handed: Right
#

Quit:

Past Surgical History

Surgeries/Hospitalizations	Year	Complications

